Mr. Speaker, let me go on and talk just a little bit about H.R. 2585. That will address some of the problems that are faced by the physicians who are in practice now, the physicians who are the primary source of care for our Medicare patients. As baby boomers retire, the demand for services is going to go nowhere but up, and if the physician workforce trends of today continue, we may not be talking about a Medicare funding problem. We may be talking about why there is no one there to take care of our seniors.

Year after year, there's a reduction in the reimbursement payments from the Center of Medicare and Medicaid Services to physicians for the services they provide for Medicare patients. It's not a question of doctors just simply wanting to make more money. It's about a stabilized repayment for services that have already been rendered, and it isn't just affecting doctors. The problem also affects patients. It becomes a real crisis of access.

Not a week goes by that I don't get a letter from a physician from somewhere in the country or a fax that says, you know what, I've just had it up to here, and I'm going to stop seeing Medicare patients. I'm going to retire early. I'm no longer going to accept new Medicare patients in my practice, or I'm going to restrict those procedures that I offer to Medicare patients.

And, unfortunately, I know this is happening because I saw it in the hospital environment before I left practice 5 years ago to come to Congress, and I hear it in virtually every town hall that I have in my district. Someone will raise their hand and say how come on Medicare, you turn 65 and you've got to change doctors. And the answer is, because their doctor found it no longer economically viability to continue to see Medicare patients because they weren't able to pay for the cost of delivering the care. They weren't able to cover the cost of delivering the care.

Now, Medicare payments to physicians are modified annually under a formula that is known as the ''sustainable growth rate.'' Because of flaws in the process and flaws built into the formula, the SGR-mandated physician fee cuts in recent years have only been moderately averted at the last minute; and if long-term congressional action is not implemented, the SGR will continue to mandate physician cuts.

Now, unlike hospital reimbursement rates which closely follow the consumer price index that measures the cost of providing care, physician reimbursements do not. I have a graph here, again from the Texas Medical Association, that shows based on various calendar years what the cuts in the SGR formula have amounted to as far as physician reimbursement versus what the cost-of-living adjustment has been for Medicare Advantage, the Medicare HMOs, for hospitals, for nursing homes, for pharmaceuticals now would be the same type of formula.

Only physicians are asked to live under this formula. In fact, ordinarily Medicare payments do not cover or only cover about 65 percent of the actual cost of providing the patient services. Can you imagine going to any industry or company and ask them to continue in business when you're only paying them 65 percent of what it costs them to stay in business?

The SGR links physician payments updates to the gross domestic product and the reality is that has no relationship to the cost of providing patient services. But simply the repeal of the SGR has been difficult because it costs a lot of money; but perhaps if we do it over time, perhaps we can bring that down to a level that's manageable.

Paying physicians fairly will extend the career of practicing physicians who would otherwise opt out of the Medicare program, seek early retirement or severely restrict those procedures that they offer to their Medicare patients. It also has the effect of ensuring an adequate network of doctors available to older Americans as this country makes a transition to the physician workforce of the future.

In the new physician payment stabilization bill, the SGR formula would be repealed in the year 2010, 2 years from now, but would also provide incentive payments based on quality reporting and technology improvements. These incentive payments would be installed to protect the practicing physician against that 5 percent cut that is estimated to occur in 2008 and 2009.

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Note that this would be voluntary. No one would be required to participate in either program that dealt with quality improvement or technology improvement, but it would be available to doctors or practices who wanted to offset the proposed cuts that would occur in physician reimbursement until the 2 years time the physician repayment formally can be repealed.

Now I know that a lot of the doctors don't like the concept of postponing the SGR by 2 years. In fact, in the bill 2585, by resetting the baseline of the SGR formula, a technique that we used in this Congress back in 2003, by resetting the baseline, the amount of cuts contemplated for 2008 and 2009 are actually modified significantly, and, in fact, there may not be a cut at all in 2008 or 2009. This could translate into an actual positive update for physicians in those 2 years.

But the critical thing, in my mind, is that we have to be, regardless of what we decide to do over the next 2 years, we have got to be working on a long-term solution to get out from under the tyranny of the SGR formula.

Now, why do it this way? Why not just bite the bullet and get the SGR out of the way and get it repealed once and for all? The problem is, it costs a tremendous amount of money to do that. The problem we have in Congress is, if we are required to submit all legislation that we propose to the Congressional Budget Office to find out how much something costs, we are going to be spending the taxpayers' money, we have got to know how much we are going to spend, over what time will we spend it.

Because of the constraints in the Congressional Budget Office, we are not allowed to do what's called dynamic scoring. We can't look ahead and say, you know, if we do this, we are going to save money. The Congressional Budget Office doesn't work that way.

That's why postponing the renewal of the SGR by 2 years, take that savings that is going to occur over those 2 years, sequester it and aggregate that savings and put it towards paying for the repeal of the SGR and replacing it with a cost of living index, the Medicare, economic index that would be fundamentally much fairer.

One of the main thrusts of the bill is to require the Centers for Medicaid and Medicare Services to do just exactly that and to look at the 10 diagnostic codes for which most of the monetary expenditures are rendered. You know the old bank robber, Willie Sutton, when he was asked why he would rob the bank, he said, that's where the money is. Let's go to where the money is. Let's go to those top 10 procedures and diagnoses that spend the greatest amount of Medicare and look for where the greatest amount of savings can be found within that.

The same considerations actually apply to the Medicaid program as well, so it will be useful to go through this process in identifying those top 10 conditions and trying to modify things so that the delivery of care for those top 10 conditions actually ends up costing us less.

With the time that remains, I know I have talked about a lot of stuff tonight, a lot of it is technically very complex. I will admit it, a lot of it is actually very boring to listen to. But it is an incredibly important subject, and it is an incredibly important story that we have to tell here in Congress. It's a story of how the most advanced, most innovative and most appreciated health care system in the world actually needs a little help itself.

The end of the story should read, ''happily ever after,'' but how are we going to get to that conclusion? In fact, the last chapter may well read, ''private industry leads to a healthy ending.''

At the beginning of this hour, we talked about the debate that will forever change the face of health care in this country. Again, I think it's important to understand, that we understand here in Congress, that we understand what's working in our system and what is not. We can't delay making the changes and bringing health care into the 21st century.

I believe the only way we can make this work is if we allow the private sector to be involved, to stay involved and, in fact, lay the foundation for the improvements that we all want.